

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4706	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  ISLAND HOME PARK HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  A Licensure survey and complaint investigation #33294, were completed on March 11, 2014, at Island Home Park Health And Rehab. No deficiencies were cited under Chapter 1200-08-06, Standards for Nursing Homes.	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

QP5011

If continuation sheet 1 of 1

MAR 27 2014